

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>004458</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>08/29/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>SETTLERS HOUSE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3304 MONROE ST LA PORTE, IN 46350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Dates of Survey: August 28 &amp; 29, 2013</p> <p>Facility number: 004458 Provider number: 004458 AIM number: N/A</p> <p>Survey team: Yolanda Love, RN-TC Lara Richards, RN</p> <p>Census bed type: Residential: 31 Total: 31</p> <p>Census payor type: Other: 31 Total: 31</p> <p>Sample: 9</p> <p>Settlers House was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey.</p> <p>Quality Review 08/29/13 by Lisa McColly</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE